

Title: **Basics of Evaluation & Management Coding**

Session: **W-5-1000**



Objectives

- Understand the nature of E/M services
 - Understand the relationship between ICD-9-CM and E/M codes
 - Understand the relationship between medical necessity and E/M codes
 - Be able to define E/M services
- Correctly determine the type of E/M service provided
- Identify the components and key components of E/M codes
- Understand how each E/M key component is leveled



Overview

- Nature of E/M Services
- Evaluation and Management Defined
- Encounter Types
- E/M Office Visits
 - History
 - Exam
 - Medical Decision-Making
 - Overall Leveling



Nature of E/M Services: ICD-9 and CPT Coding Relationship

- ICD-9 codes explain WHY the service was performed
- CPT codes explain WHAT service was performed
- Diagnosis codes MUST support the CPT code(s) assigned



Nature of E/M Service: Medical Necessity

- Medical necessity – Patient's presenting problem or reason for the visit
 - Level of service provided is dependent upon what is medically reasonable and necessary as demonstrated in the documentation, not just the amount of documentation
 - Supported by ICD-9 diagnoses codes assigned



Nature of E/M Services: Evaluation and Management Defined

- The professional services provided face-to-face by provider during a visit
- Visit: Healthcare characterized by the professional examination and/or evaluation of a patient and the delivery or prescription of a care regimen. For a visit to be counted, there must be:
 - Interaction between an authorized patient and a healthcare provider,
 - Independent judgment about the patient's care, and
 - Documentation (including, at a minimum, the date, clinic name, reason for visit, patient assessment, description of the interaction between the patient and the healthcare provider, disposition, and signature of the provider of care) in the patient's authorized record of medical treatment. (DoD 6010.15-M)



E/M Encounter Types

- Outpatient
 - New
 - Established
 - ER
 - Consult
 - Preventive
- Inpatient
 - Initial (Admission)
 - Subsequent
 - Consult
 - Rounds



E/M Encounter Types

- Outpatient Office Visit
 - New vs. Established patient: 99201- 99215
 - MHS Coding Guidelines 3.1.6.1:
 - A new patient is one who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice in the previous three years.
 - A new patient may receive initial professional services as an inpatient or outpatient. Subsequent professional services would be coded as an established patient. The encounter that determines a new patient is the first encounter a patient has that meets the criteria above and meets the requirements of a visit. Occasions of service are not coded as a new patient encounter.
 - MHS Coding Guidelines 3.1.6.2
 - An established patient is one who has received professional services from the provider or another provider of the same specialty who belongs to the same group practice in the previous three years. A common error in DoD is an optometrist new to the facility coding all patients as new.



Encounter Types

- Outpatient
 - Consult: Chapter 4, MHS Coding Guidelines
 - 4.1. Consultation Guidelines
 - The MHS no longer recognizes consultation codes (99241-99245 and 99251-99255). Providers will use either a new patient or established patient E&M service, depending upon the setting (inpatient or outpatient) and if the patient has previously been seen by a privileged provider of the same specialty at the same facility.



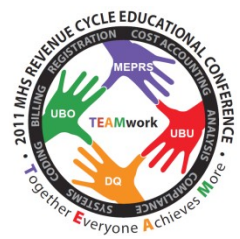
Encounter Types

- Outpatient
 - Consult: Chapter 4, MHS Coding Guidelines
 - 4.2. Outpatient Guidance
 - Use an established E&M code (99211-99215) for the initial encounter if the patient has been seen face-to-face by a privileged provider in the same specialty within 3 years of the date of service.
 - New patient if the patient has not received any face-to-face services by a privileged provider in the same specialty within 3 years of the date of service.
 - Professional components of procedures previously performed, in the absence of a face-to-face service, are not to be used in designating a patient as established.
 - A subspecialist may code a new patient visit (99201-99205) for the initial encounter if the patient has not been seen by a privileged provider of the same subspecialty within 3 years of the date of service, and the documentation of the encounter clearly demonstrates that the subspecialist is being consulted for a subspecialty issue.



Encounter Types

- Outpatient
 - 4.2.1 Emergency Department
 - The emergency department provider requests the specialist take over care or a portion of care. The emergency department does not intend for the patient to receive follow-up care in the emergency department. To code emergency department services with separate specialist services, two ADM records will be created.
 - ED Encounter: The ED provider will document services provided. In the documented plan of care, the emergency department provider will indicate a portion or all of the care will be transferred to the specialist. The emergency department provider will generally use a code in the 99281-99285 series and collect the care in code BIAA of Medical Expense and Performance Reporting System (MEPRS).



Encounter Types

- Outpatient
 - 4.2.1 Emergency Department
 - The specialist will document services in a separate document. The specialist will have an appointment generated in the clinic, usually a *walk-in*. The appointment will be marked *kept*, which will generate a report to be completed in the ADM. This report will be separate from the ADM report generated in the emergency department. The specialist will usually code an office visit range of 99201-99215 in the specialist's outpatient clinic MEPRS.



Encounter Types

- Preventive

- Physicals and well-baby visits
 - Categorized by age and patient status
 - “It is the privileged provider’s clinical judgment as to what constitutes age and gender appropriate history and exam” (MHS Coding Guidelines 6.14.1.1.1)
 - DoD Rule (MHS Coding Guidelines 6.14)
 - If an additional problem or issue is identified and treated, an additional office E&M code may be warranted.
 - If the encounter intent is preventive (e.g., a physical), code the preventive E&M encounter (e.g., 99384–7, 99394–7) first, even though problems or issues addressed constitute an additional problem-oriented E&M code (e.g., 99212) based on the separate problem-oriented documentation. Append modifier -25 to the problem-oriented E&M (e.g., 99212-25).
 - Documentation points to preventive medicine codes when a patient presents for routine services (annual exam) and documentation does not show that a significant problem is addressed. Documentation points to preventive medicine codes when there are no patient complaints, no symptoms, and no significant problem or abnormality is recorded. (MHS Coding Guidelines 6.14.1.1.3)



Encounter Types

- Preventive

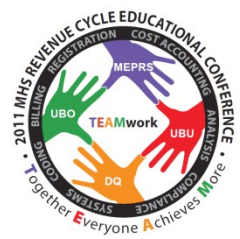
- Counseling and risk factor reduction

- The appropriate E&M codes should be assigned based on the documentation of the services performed: Counseling or risk factor reduction E&M codes include 99401-99404 and 99411-99412. To determine if the counseling or risk factor reduction codes are appropriate, ask: *Was the encounter for an examination, education, or counseling?*
 - These codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness.
 - The code selection is based on time.
 - Documentation must support the reason for the amount of time used. For instance: *Counseled on safe sex, 30 minutes* would not adequately explain the amount of time involved.



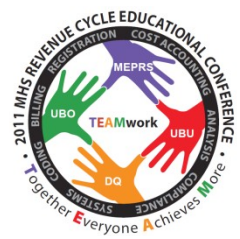
Encounter Types

- Global Surgical Period (MHS Coding Guidelines 5.3.2)
 - Surgical procedures have a global period (0, 10, or 90 days).
 - Global period includes preoperative services, the procedure, and uncomplicated postoperative care.
 - For uncomplicated postoperative care, assign code 99024
 - An E&M code is typically not used on an encounter when a decision is made to perform a minor procedure (0 – 10 day global period) immediately prior to performing the procedure.
 - When a patient has had surgery at another facility, the first follow-up at the new facility will be coded with the surgical procedure code and modifier 55 (postoperative care only).
 - Complicated postoperative services are coded to the appropriate postoperative complication codes and E&M services.



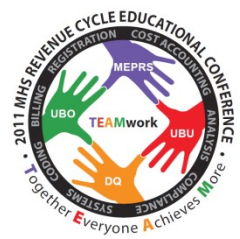
E/M Office Visit

- Chapter 3 of the MHS Coding Guidelines:
 - “Facilities should indicate in their compliance plan which set of CMS guidelines each clinical service will follow. Indicate how the encounter was audited—using the CMS 1995 or 1997 E&M guidelines.”
- CMS Guidelines
 - E/M Documentation Guidelines:
 - http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf
 - 1995 Guidelines:
 - <http://www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf>
 - 1997 Guidelines
 - <http://www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf>



E/M Components

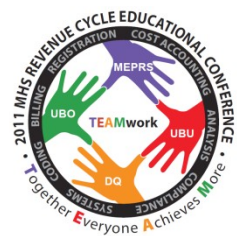
- E/M Components
 - History*
 - Examination*
 - Medical Decision-Making*
 - Counseling
 - Coordination of Care
 - Nature of Presenting Problem
 - Time
- * = Key Component



History Component

- History - Composed of:

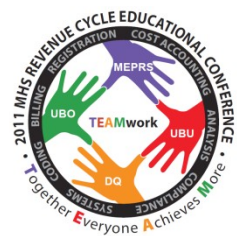
- Chief Complaint: Describes the patient's presenting sign, symptom, problem, condition, or reason for the visit
- 3 additional components:
 - History of Present Illness: A chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present.
 - Review of Systems: An inventory of body systems obtained by asking a series of questions in order to identify signs and/or symptoms that the patient may be experiencing or has experienced. Answers to questions asked to identify signs and/or symptoms related to the patient's chief complaint that the patient may have or has had.
 - Past, Family, and Social History: A review of the patient's:
 - Past history including experiences with illnesses, operations, injuries, and treatments;
 - Family history, including a review of medical events, diseases, and hereditary conditions that may place him or her at risk; and
 - Social history including an age appropriate review of past and current activities.



History of Present Illness

Location	Left	Right	Proximal	Distal
Duration	Since this morning	1 week	Several months	48 hours
Modifying Factors	Better after eating	Relieved by aspirin	Worsens when	Took ____ with no relief
Quality	Sharp	Dull	Shooting	Throbbing
Severity	Pain is 6 on a scale of 1-10	Severe	Slight	Intolerable
Timing	Daily	Began at midnight	Sporadic	Nocturnal
Context	During exercise	Occurred at	While running	When walking, but not when standing
Associated Signs & Symptoms	Without fever	Headache	Nausea/vomiting	No LOC

Example: 25 y/o AD male c/o sharp pain (6/10) x 2 days when flexing R arm; no relief w/ Tylenol.

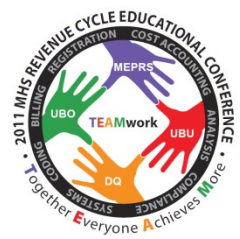


1995 HPI Leveling

<input type="checkbox"/> Chief Complaint	<input type="checkbox"/> New Patient	<input type="checkbox"/> Est Patient Consultation	<input type="checkbox"/>
HISTORY			
HPI (History of Present Illness) <input type="checkbox"/> Location <input type="checkbox"/> Duration <input type="checkbox"/> Mod. Factors <input type="checkbox"/> Quality <input type="checkbox"/> Severity <input type="checkbox"/> Timing <input type="checkbox"/> Context <input type="checkbox"/> Associated signs & symptoms	<input type="checkbox"/> Brief (1-3 elements)	<input type="checkbox"/> Extended (4 or more elements)	

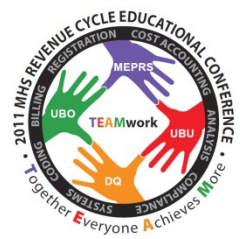
1997 HPI Leveling

<input type="checkbox"/> Chief Complaint	<input type="checkbox"/> New Patient	<input type="checkbox"/> Est Patient Consultation	<input type="checkbox"/>
HISTORY			
HPI (History of Present Illness) <input type="checkbox"/> Location <input type="checkbox"/> Duration <input type="checkbox"/> Mod. Factors <input type="checkbox"/> Quality <input type="checkbox"/> Severity <input type="checkbox"/> Timing <input type="checkbox"/> Context <input type="checkbox"/> Associated signs & symptoms OR Status of chronic/inactive conditions 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	<input type="checkbox"/> Brief (1-3 elements, or status of 1-2 chronic conditions)	<input type="checkbox"/> Extended (4 or more elements, or status of 3 chronic or inactive conditions)	



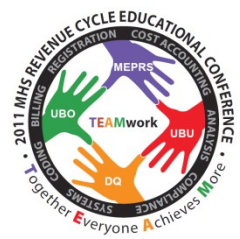
Leveling Review of Systems

ROS (Review of Systems) <input type="checkbox"/> Constitutional <input type="checkbox"/> Eyes <input type="checkbox"/> ENMT <input type="checkbox"/> Card/vasc <input type="checkbox"/> Neuro <input type="checkbox"/> GI <input type="checkbox"/> Musculo <input type="checkbox"/> Resp <input type="checkbox"/> GU <input type="checkbox"/> Hem/Lymph <input type="checkbox"/> Psych <input type="checkbox"/> All/imm <input type="checkbox"/> Integ <input type="checkbox"/> Endo	<input type="checkbox"/> None	<input type="checkbox"/> Pertinent to problem/chief complaint (1 system)	<input type="checkbox"/> Extended (2-9 systems including 1 system pertinent to problem / chief complaint)	<input type="checkbox"/> Complete (10 or more systems including 1 system pertinent to problem / chief complaint)
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Past, Family, Social History

PFSH (Past medical, Family and Social History) <ul style="list-style-type: none"> <input type="checkbox"/> Past (patient's illnesses, operation, injuries & treatments) <input type="checkbox"/> Family (review of medical events in pt's family incl. hereditary disease placing pt at risk) <input type="checkbox"/> Social (age appropriate review of past & current activities) 	<input type="checkbox"/> None		<input type="checkbox"/> Pertinent (1 history area)	<input type="checkbox"/> Complete New or Consult : 3 history areas Established: 2 history areas
* Complete PFSH: 2 Hx areas: a) Established pts. - office visit; domiciliary care; home care; b) Emergency dept. visit; and, c) Subsequent nursing facility care. 3 Hx areas: a) New patients. - office visit; domiciliary care; home care; b) Consultations; c) Initial hospital care; d) hospital observation; and, e) Comprehensive nursing facility assessments.	Problem Focused (PF)	Expanded Problem Focused (EPF)	Detailed (D)	Comprehensive (C)



1995 History Leveling

<input type="checkbox"/> Chief Complaint	<input type="checkbox"/> New Patient <input type="checkbox"/> Est Patient Consultation <input type="checkbox"/>			
HISTORY				
HPI (History of Present Illness) <input type="checkbox"/> Location <input type="checkbox"/> Duration <input type="checkbox"/> Mod. Factors <input type="checkbox"/> Quality <input type="checkbox"/> Severity <input type="checkbox"/> Timing <input type="checkbox"/> Context <input type="checkbox"/> Associated signs & symptoms	<input type="checkbox"/> Brief (1-3 elements)		<input checked="" type="checkbox"/> Extended (4 or more elements)	
ROS (Review of Systems) <input type="checkbox"/> Constitutional <input type="checkbox"/> Eyes <input type="checkbox"/> ENMT <input type="checkbox"/> Card/vasc <input type="checkbox"/> Neuro <input type="checkbox"/> GI <input type="checkbox"/> Musculo <input type="checkbox"/> Resp <input type="checkbox"/> GU <input type="checkbox"/> Hem/Lymph <input type="checkbox"/> Psych <input type="checkbox"/> All/imm <input type="checkbox"/> Integ <input type="checkbox"/> Endo	<input type="checkbox"/> None	<input type="checkbox"/> Pertinent to problem (1 system)	<input checked="" type="checkbox"/> Extended (2-9 systems including 1 pertinent) <input type="checkbox"/> Complete (10 or more systems including 1 pertinent)	
PFSH (Past medical, Family and Social History) <input type="checkbox"/> Past (patient's illnesses, operation, injuries & treatments) <input type="checkbox"/> Family (review of medical events in pt's family incl. hereditary disease placing pt at risk) <input type="checkbox"/> Social (age appropriate review of past & current activities) * Complete PFSH: 2 Hx areas: a) Established pts. - office visit; domiciliary care; home care; b) Emergency dept. visit; and, c) Subsequent nursing facility care. 3 Hx areas: a) New patients. - office visit; domiciliary care; home care; b) Consultations; c) Initial hospital care; d) hospital observation; and, e) Comprehensive nursing facility assessments.	<input type="checkbox"/> None		<input checked="" type="checkbox"/> Pertinent (1 history area) <input type="checkbox"/> Complete New or Consult : 3 history areas Established: 2 history areas	
	Problem Focused (PF)	Expanded Problem Focused (EPF)	<input checked="" type="checkbox"/> Detailed (D)	<input type="checkbox"/> Comprehensive (C)
	Final level of history requires 3 components above met or exceeded			



1997 History Leveling

<input type="checkbox"/> Chief Complaint	<input type="checkbox"/> New Patient Consultation <input type="checkbox"/> Est Patient			
HISTORY				
HPI (History of Present Illness) <input type="checkbox"/> Location <input type="checkbox"/> Duration <input type="checkbox"/> Mod. Factors <input type="checkbox"/> Quality <input type="checkbox"/> Severity <input type="checkbox"/> Timing <input type="checkbox"/> Context <input type="checkbox"/> Associated signs & symptoms OR Status of chronic/inactive conditions 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	<input type="checkbox"/> Brief (1-3 elements, or status of 1-2 chronic conditions)		<input checked="" type="checkbox"/> Extended (4 or more elements, or status of 3 chronic or inactive conditions)	
ROS (Review of Systems) <input type="checkbox"/> Constitutional <input type="checkbox"/> Eyes <input type="checkbox"/> ENMT <input type="checkbox"/> Card/vasc <input type="checkbox"/> Neuro <input type="checkbox"/> GI <input type="checkbox"/> Musculo <input type="checkbox"/> Resp <input type="checkbox"/> GU <input type="checkbox"/> Hem/Lymph <input type="checkbox"/> Psych <input type="checkbox"/> All/imm <input type="checkbox"/> Integ <input type="checkbox"/> Endo	<input type="checkbox"/> None	<input type="checkbox"/> Pertinent to problem (1 system)	<input checked="" type="checkbox"/> Extended (2-9 systems including 1 pertinent)	<input type="checkbox"/> Complete (10 or more systems including 1 pertinent)
PFSH (Past medical, Family and Social History) <input type="checkbox"/> Past (patient's illnesses, operation, injuries & treatments) <input type="checkbox"/> Family (review of medical events in pt's family incl. hereditary disease placing pt at risk) <input type="checkbox"/> Social (age appropriate review of past & current activities) * Complete PFSH: 2 Hx areas: a) Established pts. - office visit; domiciliary care; home care; b) Emergency dept. visit; and, c) Subsequent nursing facility care. 3 Hx areas: a) New patients. - office visit; domiciliary care; home care; b) Consultations; c) Initial hospital care; d) hospital observation; and, e) Comprehensive nursing facility assessments.	<input type="checkbox"/> None		<input checked="" type="checkbox"/> Pertinent (1 history area)	<input type="checkbox"/> Complete New or Consult : 3 history areas Established: 2 history areas
	Problem-Focused (PF)	Expanded Problem Focused (EPF)	<input checked="" type="checkbox"/> Detailed (D)	<input type="checkbox"/> Comprehensive (C)
Final level of history requires 3 components above met or exceeded				



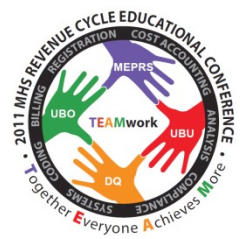
Physical Examination

Level of Exam	CPT Description	1995 Guidelines	1997 Guidelines
Problem Focused	Limited to affected body area or organ system	1 (affected) body area or organ system	1 – 5 bulleted elements
Expanded Problem Focused	Limited exam of affected body area or organ system and other symptomatic or related organ systems	2-7 body areas or organ systems	6 – 11 bulleted elements
Detailed	Extended exam of affected body area or organ system and other symptomatic or related organ systems	Extended exam (<u>≥ 3 documented findings</u>) of <u>affected body area or organ system</u> + 2-7 additional body areas or organ systems	12 – 17 bulleted elements for two or more systems
Comprehensive	General multi-system exam	8 or more organ systems	18 or more bulleted elements for 9 or more systems
	Complete single organ system exam	Not defined	See 1997 CMS requirements for individual single system exams



Documentation of Examination

- Includes body areas and/or organ systems pertinent to the encounter
- Findings of each area or system examined is individually documented
- Finding may be documented as:
 - Negative or normal
 - Positive or abnormal with explanation of finding(s)
 - Example – Respiratory: Rales, crackles



1995 Examination

EXAMINATION

Body Areas:

☐ Head
(w/face)

☐ Chest,
w/breast &
axillae

☐ Abdomen

☐ Back,
(w/spine)

☐ Neck
(thyroid)

☐ Genitalia/groin
/buttocks

☐ Each
Extremity

Organ Systems:

☐ Constitutional
☐ Eyes
☐ Ears, nose,
mouth,
throat

☐ Skin
☐ Respiratory
☐ Card/vas
cular

☐ GI
☐ GU
☐ Neuro

☐ Musculoskeletal
☐ Heme /lymph
/imm
☐ Psych

☐
1 body
area or
System

☐
Limited
exam of
Affected
area +
2-7 body
areas or
systems

☐
Expanded
exam (≥ 3
documente
d
elements)
of
affected
area
+ 2-7
additional
body areas
or
systems

☐
8 or more
Organ
Systems

**Proble
m
Focuse
d
(PF)**

**Expande
d
Problem
Focused
(EPF)**

**Detailed
(D)**

**Comprehen
sive
(C)**



Medical Decision-Making: CMS and CPT Description

- Refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following elements:
 1. The number of possible diagnoses and/or the number of management options that must be considered (Box A);
 2. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed (Box B); and
 3. The risk of significant complications, morbidity, and/or mortality as well as co-morbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options (Box C).



Medical Decision-Making

- 3 Elements:
 - Number of diagnoses/management options
 - Amount of data reviewed/ordered
 - Level of risk of complications and/or morbidity or mortality
- 4 Levels:
 - Straightforward
 - Low
 - Moderate
 - High
- To qualify for a given type of decision-making, two of the three elements must be met or exceeded



Medical Decision-Making: Diagnoses and/or Management Options

- Primary Diagnosis:
 - MHS Guidelines 2.2.1: The primary diagnosis is the reason for the encounter, as determined by the documentation. The chief complaint does not have to match the primary diagnosis.
 - AMA CPT 2011 pg. 6: Presenting Problem = “A disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter.”
- Secondary Diagnoses:
 - MHS Coding Guidelines 2.2.2: Conditions or diseases that exist at the time of the encounter, but do not affect the current encounter are not coded. Documented conditions or diseases that affect the current encounter, are considered in decision making, and are treated or assessed, are coded.
 - AMA CPT 2011 pg. 9: “Co-morbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision-making.”



Medical Decision-Making: Diagnoses and/or Management Options

- Specificity:
 - MHS Coding Guidelines 2.2.3: Specificity in coding is assigning all the available digits for a code. Diagnostic codes should be assigned at the highest level of specificity.
- 3.1.1.2 Self-Limited/Minor Problems
 - A common error in E&M leveling is to assign a self-limited or minor problem in the “Number of Diagnoses or Treatment Options” component of medical decision-making to the level of a new problem, creating a tendency to overvalue the level of medical decision-making and increasing the risk of overcoding. In order to address this type of error, the CPT definition of a self-limited or minor problem will be followed.
 - CPT defines a self-limited or minor problem as “a problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status, OR has a good prognosis with management/compliance.”



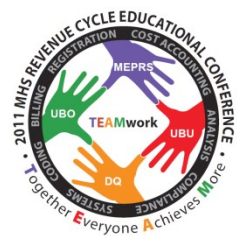
Medical Decision-Making: Diagnoses and/or Management Options

- 3.1.1.2 Self-Limited/Minor Problems
 - In order to comply with this CPT definition, unless the provider documents risk factors specific to the patient (e.g., co-morbidities or other extenuating circumstances) that indicate a specific increased risk of altering the health status of the patient or of worsening his or her prognosis, any self-limited or minor problems should be considered "self-limited or minor" in determining the level for diagnoses/management options and level of risk in medical decision-making. Simply stating potential risk factors or circumstances common to all patients with the problem will not justify considering the problem beyond a self-limited/minor problem.
 - Example of self-limited/minor problem: 22-year-old male (patient of Dr A, seen by Dr B) presents for 2-day history of cough and congestion. Patient is otherwise healthy, without any other positive findings noted in Review of Systems for ENT and Respiratory organ systems or past medical, family, or social history. Provider performed exam and diagnosed patient with a URI, and prescribed a 10-day course of antibiotics.



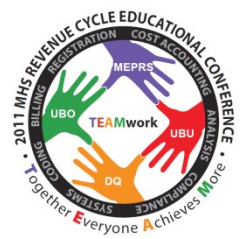
Diagnosis Code Selection

- Must be supported by documentation in the current note
- Specific as possible (e.g. pneumonia vs. strep pneumonia)
- Include acuity of diagnosis (e.g., acute, severe, chronic, mild, moderate, etc.)
- May be taken from final assessment or chief complaint
- Use signs/symptoms if unable to make definitive diagnosis during encounter
- Cannot code diagnosis described as “rule out... probable... possible...questionable...”
- Also code secondary conditions affecting treatment



Medical Decision-Making: Diagnoses and/or Management Options

Self-limited or minor: (CPT: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status or has a good prognosis with management/compliance)	_____ problems	X 1 point	_____ points (max = 2)
Established problem: Stable or improving (By documentation)	_____ problems	X 1 point	_____ points (max = 2)
Established problem: Worsening (By documentation)	_____ problems	X 2 points	_____ points
New problem: No additional workup planned (Documentation does not indicate any diagnostic tests performed or ordered)	_____ problems	X 3 points	_____ points (max = 3)
New problem: Additional work-up planned (diagnostic tests performed at encounter are documented &/or tests ordered are documented)	_____ problems	X 4 points	_____ points
Total Points:			



Data Reviewed or Ordered

Item (Documentation required)	Points
Review &/or order of clinical lab tests	1
Review &/or order of tests in Radiology section of CPT	1
Review &/or order of tests in Medicine section of CPT	1
Discuss tests with performing physician	1
Decision to obtain old records (Must identify source and reason for decision)	1
Review & summarize old records (must identify source, provide summary and relevance to current problem)	2
Independent visualization and interpretation of image, tracing, or specimen (Not a review of a report; must document own interpretation)	2
Total Points:	



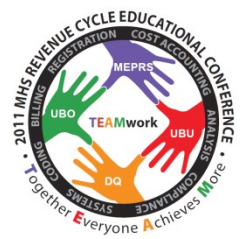
Level of Risk

C. Risk of Complications and/or Morbidity or Mortality				
C.1 Levels of Risk				
Level of Risk	Nature of Presenting Illness/Problem(s)	Diagnostic Procedure Ordered	Management Options Selected	
Minimal	<ul style="list-style-type: none">One self-limited or minor problems; e.g., cold, insect bite, tinea corporis	<ul style="list-style-type: none">Laboratory tests requiring venipunctureChest x-raysEKG/EEGUrinalysisUltrasound, e.g., echocardiographyKOH prep	<ul style="list-style-type: none">RestGarglesElastic BandagesSuperficial dressings	
Low	<ul style="list-style-type: none">Two or more self-limited or minor problemsOne stable chronic illness; e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPHAcute uncomplicated illness or injury; e.g., cystitis, allergic rhinitis, simple sprain	<ul style="list-style-type: none">Physiological tests not under stress; e.g., pulmonary function testsNon-cardiovascular imaging studies with contrast; e.g., barium enemaSuperficial needle biopsiesClinical laboratory tests requiring arterial punctureSkin biopsies	<ul style="list-style-type: none">Over-the-counter drugsMinor surgery with no identified risk factorsPhysical therapyOccupational therapyIV fluids without additives	
Moderate	<ul style="list-style-type: none">One or more chronic illnesses with mild exacerbation, progression, or side effects of treatmentTwo or more stable chronic illnessesUndiagnosed new problem with uncertain prognosis, e.g., lump in breastAcute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitisAcute complicated injury e.g., head injury with brief loss of consciousness	<ul style="list-style-type: none">Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress testDiagnostic endoscopies with no identified risk factorsDeep needle or incisional biopsyCardiovascular imaging studies w/contrast and no identified risk factors, e.g., arteriogram, cardiac catheterizationObtain fluid from body cavity, e.g., lumbar puncture thoracentesis, culdocentesis	<ul style="list-style-type: none">Minor surgery w/ identified risk factorsElective major surgery (open, percutaneous, or endoscopic) w/ no identified risk factorsPrescription drug managementTherapeutic nuclear medicineIV fluids with additivesClosed treatment of fracture or dislocation without manipulation	
High	<ul style="list-style-type: none">One or more chronic illness with severe exacerbation, progression, or side effects of treatmentAcute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failureAn abrupt change in neurologic status, e.g., seizures, TIA, weakness, or sensory loss	<ul style="list-style-type: none">Cardiovascular imaging studies with contrast with identified risk factorsCardiac electrophysiological testsDiagnostic endoscopies with identified risk factorsDiscography	<ul style="list-style-type: none">Elective major surgery (open, percutaneous, or endoscopic) with identified risk factorsEmergency major surgery (open, percutaneous, or endoscopic),Parenteral controlled substancesDrug therapy requiring intensive monitoring for toxicityDecisions not to resuscitate or to de-escalate care because of poor prognosis	
BOX C. Risk of Complications and/or Morbidity or Mortality				
Nature of presenting illness/problem(s)	Minimal	Low	Moderate	High
Risk conferred by diagnostic procedure options	Minimal	Low	Moderate	High
Risk conferred by therapeutic management options	Minimal	Low	Moderate	High
Bring results to BOX D. Final Results for Medical Decision-Making	Final Risk determined by highest level of any of the 3 components above			
	Minimal	Low	Moderate	High



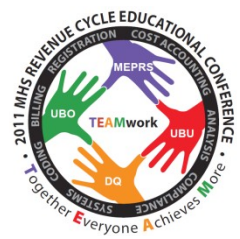
Leveling Medical Decision-Making - Box D

BOX D. Final Result for Complexity of Medical Decision-Making (MDM)					
A	Number of diagnoses and/or management options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Amount and complexity of data reviewed or ordered	≤ 1 None/Minimal	2 Limited	3 Multiple	≥ 4 Extensive
C	Risk of complications for morbidity and/or mortality	Minimal	Low	Moderate	High
Type of medical decision-making		Final MDM requires that <u>2 of 3 of the above components are met or exceeded</u>			
		Straight Forward (S)	Low Complexity (L)	Moderate Complexity (M)	High Complexity (H)



Overall Leveling

EVALUATION AND MANAGEMENT (E & M) LEVEL OF SERVICE									
E & M Code	History	Exam	MDM	Average Time	E & M Code	History	Exam	MDM	Average Time
New Patient Office/Outpatient Requires 3 of 3 components met					Established Office/Outpatient Visit - Requires 2 of 3 components met. MDM must be 1 of the 2 required components met				
99201	PF	PF	S	10	99211	N/A	N/A	N/A	5
99202	EPF	EPF	S	20	99212	PF	PF	S	10
99203	D	D	L	30	99213	EPF	EPF	L	15
99204	C	C	M	45	99214	D	D	M	25
99205	C	C	H	60	99215	C	C	H	40



Time Based Coding

TIME

If the attending physician documented that the visit was dominated (more than 50%) by counseling or coordinating care, time may be used to determine the level of service. In addition to any history, examination or MDM documented, documentation must include the total visit time, counseling/coordination of care time, and details of the counseling/coordination of care. Details may include prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, etc.

If all the answers to the below 3 questions are “yes”, the total visit time may be used to select the level of the service.

Does the attending’s documentation indicate the total face-to-face visit time?

☐ Yes
☐ No

Does the attending’s documentation indicate that more than 50% of the time was counseling or coordinating the patient’s care?

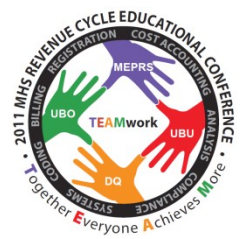
☐ Yes
☐ No

Does documentation describe the content of counseling or coordinating care?

NOTE: DoD Rule (MHS 3.1.5.2):

- AHLTA Documentation: When a provider selects greater than 50% of time spent “counseling and/or coordinating care” and also selects the appropriate amount of floor time (face to face) then time in and time out requirement has been met.
- **Detailed documentation must indicate specifics on the counseling or coordination of care, discussion of why the additional time was necessary, what occurred during the additional time, and how much time was spent.**
- **Note: “counseled on condition, diagnosis, or treatment alternatives” is not acceptable documentation in and of itself.**

☐ Yes
☐ No



Overall Leveling

EVALUATION AND MANAGEMENT (E & M) LEVEL OF SERVICE									
E & M Code	History	Exam	MDM	Average Time	E & M Code	History	Exam	MDM	Average Time
New Patient Office/Outpatient Requires 3 of 3 components met					Established Office/Outpatient Visit - Requires 2 of 3 components met. MDM must be 1 of the 2 required components met				
99201	PF	PF	S	10	99211	N/A	N/A	N/A	5
99202	EPF	EPF	S	20	99212	PF	PF	S	10
99203	D	D	L	30	99213	EPF	EPF	L	15
99204	C	C	M	45	99214	D	D	M	25
99205	C	C	H	60	99215	C	C	H	40



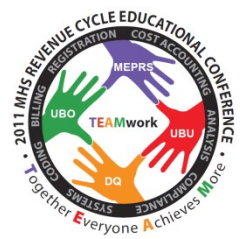
Coding Example ('95 Guidelines)

- CC/HPI: 45 y/o male carpenter, established patient, with 10 year hx of RA, h/o HTN, and h/o hyperlipidemia, c/o increasing joint pain. His joint disease has been stable in the past, but in the last 3 weeks he has noticed increasing pain (8/10) and has developed redness in several joints. He has had a low grade fever for the past week.
- ROS (+) weight increased 15 lbs (265), erythema bilateral elbows/knees, fever; (-) for tingling, numbness, chest pain, dyspnea, n/v, hematuria, mood swings/irritability.
- PFSH: No prior surgeries, (+) Fhx HTN, (-) EtOH, (+) h/o smoking (20 yr pack hx)
- Exam: Well groomed, head normocephalic, AAO x 3, appropriate mood, PERRLA, carotids w/o bruits, no cervical/axillae/inguinal lymphadenopathy, lungs clear AP, C/V RRR, abdomen NTND, nl bowel sounds, no HSM, Ext. no edema extremities, (+) erythema bilateral elbows & knees, knees TTP, (+) pain on ROM R>L elbow, bilateral knees, nl DTRs, nl gait and station
- Tests: Order ANA, CBC
- Assessment/Plan: 1) RA: Joint pain - starting to flare after long period of stable control w/ tylenol alone, prescribe short course of prednisone and re-evaluate in 1 week; consider Rheumatology consult; 2) HTN: Current management w/ Atenolol 50 mg adequate given planned management of RA.



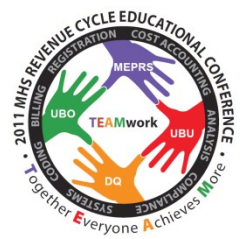
1995 History Leveling

<input checked="" type="checkbox"/> Chief Complaint	<input type="checkbox"/> New Patient	<input type="checkbox"/> Est Patient	<input type="checkbox"/> Consultation
HISTORY			
HPI (History of Present Illness) <input checked="" type="checkbox"/> Location <input checked="" type="checkbox"/> Duration <input type="checkbox"/> Mod. Factors <input type="checkbox"/> Quality <input checked="" type="checkbox"/> Severity <input type="checkbox"/> Timing <input type="checkbox"/> Context <input checked="" type="checkbox"/> Associated signs & symptoms	<input type="checkbox"/> Brief (1-3 elements)		<input checked="" type="checkbox"/> Extended (4 or more elements)
ROS (Review of Systems) <input checked="" type="checkbox"/> Constitutional <input type="checkbox"/> Eyes <input type="checkbox"/> ENMT <input checked="" type="checkbox"/> Card/vasc <input checked="" type="checkbox"/> Neuro <input checked="" type="checkbox"/> GI <input checked="" type="checkbox"/> Musculo <input checked="" type="checkbox"/> Resp <input checked="" type="checkbox"/> GU <input checked="" type="checkbox"/> Hem/Lymph <input checked="" type="checkbox"/> Psych <input type="checkbox"/> All/imm <input type="checkbox"/> Integ <input type="checkbox"/> Endo	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Extended (2-9 systems including 1 pertinent)	<input type="checkbox"/> Complete (10 or more systems including 1 pertinent)
PFSH (Past medical, Family and Social History) <input checked="" type="checkbox"/> Past (patient's illnesses, operation, injuries & treatments) <input checked="" type="checkbox"/> Family (review of medical events in pt's family incl. hereditary disease placing pt at risk) <input checked="" type="checkbox"/> Social (age appropriate review of past & current activities) * Complete PFSH: 2 Hx areas: a) Established pts. - office visit; domiciliary care; home care; b) Emergency dept. visit; and, c) Subsequent nursing facility care. 3 Hx areas: a) New patients. - office visit; domiciliary care; home care; b) Consultations; c) Initial hospital care; d) hospital observation; and, e) Comprehensive-nursing facility assessments.	<input type="checkbox"/> None		<input checked="" type="checkbox"/> Complete New or Consult : 3 history areas Established: 2 history areas
	Problem Focused (PF)	Expanded Problem Focused (EPF)	<input checked="" type="checkbox"/> Detailed (D)
	Final level of history requires 3 components above met or exceeded		



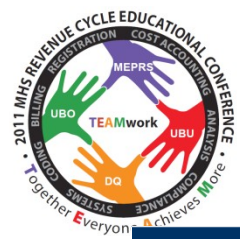
1995 Examination

EXAMINATION				
Body Areas:				<input type="checkbox"/> 1 body area or System <input type="checkbox"/> Limited exam of Affected area + 2-7 body areas or systems <input type="checkbox"/> Expanded exam (≥ 3 elements) of affected area + 2-7 Additional body areas or systems <input checked="" type="checkbox"/> 8 or more Organ Systems
<input type="checkbox"/> Head (w/face)	<input type="checkbox"/> Chest, w/breast & axillae	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Back, (w/spine)	
<input type="checkbox"/> Neck (thyroid)		<input type="checkbox"/> Genitalia/groin /buttocks	<input type="checkbox"/> Each Extremity	
Organ Systems:				
<input checked="" type="checkbox"/> Constitutional <input checked="" type="checkbox"/> Eyes <input type="checkbox"/> Ears, nose, mouth, throat	<input type="checkbox"/> Skin <input checked="" type="checkbox"/> Respiratory <input checked="" type="checkbox"/> Card/vascular	<input checked="" type="checkbox"/> GI <input type="checkbox"/> GU <input checked="" type="checkbox"/> Neuro	<input checked="" type="checkbox"/> Musculoskeletal <input checked="" type="checkbox"/> Heme /lymph /imm <input checked="" type="checkbox"/> Psych	Problem Focused (PF) Expanded Problem Focused (EPF) Detailed (D) <input checked="" type="checkbox"/> Comprehensive (C)



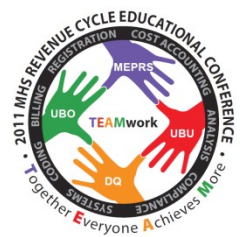
Medical Decision-Making: Diagnoses and/or Management Options

Self-limited or minor: (CPT: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status or has a good prognosis with management/compliance)	____ problems	X 1 point	____ points (max = 2)
Established problem: Stable or improving (By documentation)	1 problem (HFR)	X 1 point	1 point
Established problem: Worsening (By documentation)	1 problem (RA)	X 2 points	2 points
New problem: No additional workup planned (Documentation does not indicate any diagnostic tests performed or ordered)	____ problems	X 3 points	____ points (max = 3)
New problem: Additional work-up planned (diagnostic tests performed at encounter are documented &/or tests ordered are documented)	____ problems	X 4 points	____ points
Total Points:			3 points



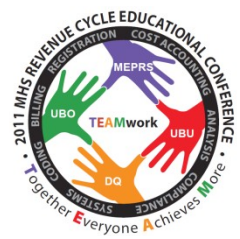
Data Reviewed or Ordered

Item (Documentation required)	Points
Review &/or order of clinical lab tests	1
Review &/or order of tests in Radiology section of CPT	1
Review &/or order of tests in Medicine section of CPT	1
Discuss tests with performing physician	1
Decision to obtain old records (Must identify source and reason for decision)	1
Review & summarize old records (must identify source, provide summary and relevance to current problem)	2
Independent visualization and interpretation of image, tracing, or specimen (Not a review of a report; must document own interpretation)	2
Total Points:	1



Level of Risk

C. Risk of Complications and/or Morbidity or Mortality				
C.1 Levels of Risk				
Level of Risk	Nature of Presenting Illness/Problem(s)	Diagnostic Procedure Ordered	Management Options Selected	
Minimal	<ul style="list-style-type: none">One self-limited or minor problems; e.g., cold, insect bite, tinea corporis	<ul style="list-style-type: none">Laboratory tests requiring venipunctureChest x-raysEKG/EEGUrinalysisUltrasound, e.g., echocardiographyKOH prep	<ul style="list-style-type: none">RestGarglesElastic BandagesSuperficial dressings	
Low	<ul style="list-style-type: none">Two or more self-limited or minor problemsOne stable chronic illness; e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPHAcute uncomplicated illness or injury; e.g., cystitis, allergic rhinitis, simple sprain	<ul style="list-style-type: none">Physiological tests not under stress; e.g., pulmonary function testsNon-cardiovascular imaging studies with contrast; e.g., barium enemaSuperficial needle biopsiesClinical laboratory tests requiring arterial punctureSkin biopsies	<ul style="list-style-type: none">Over-the-counter drugsMinor surgery with no identified risk factorsPhysical therapyOccupational therapyIV fluids without additives	
Moderate	<ul style="list-style-type: none">One or more chronic illnesses with mild exacerbation, progression, or side effects of treatmentTwo or more stable chronic illnessesUndiagnosed new problem with uncertain prognosis, e.g., lump in breastAcute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitisAcute complicated injury e.g., head injury with brief loss of consciousness	<ul style="list-style-type: none">Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress testDiagnostic endoscopies with no identified risk factorsDeep needle or incisional biopsyCardiovascular imaging studies w/contrast and no identified risk factors, e.g., arteriogram, cardiac catheterizationObtain fluid from body cavity, e.g., lumbar puncture thoracentesis, culdocentesis	<ul style="list-style-type: none">Minor surgery w/ identified risk factorsElective major surgery (open, percutaneous, or endoscopic) w/ no identified risk factorsPrescription drug managementTherapeutic nuclear medicineIV fluids with additivesClosed treatment of fracture or dislocation without manipulation	
High	<ul style="list-style-type: none">One or more chronic illness with severe exacerbation, progression, or side effects of treatmentAcute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failureAn abrupt change in neurologic status, e.g., seizures, TIA, weakness, or sensory loss	<ul style="list-style-type: none">Cardiovascular imaging studies with contrast with identified risk factorsCardiac electrophysiological testsDiagnostic endoscopies with identified risk factorsDiscography	<ul style="list-style-type: none">Elective major surgery (open, percutaneous, or endoscopic) with identified risk factorsEmergency major surgery (open, percutaneous, or endoscopic),Parenteral controlled substancesDrug therapy requiring intensive monitoring for toxicityDecisions not to resuscitate or to de-escalate care because of poor prognosis	
BOX C. Risk of Complications and/or Morbidity or Mortality				
Nature of presenting illness/problem(s)	Minimal	Low	Moderate	High
Risk conferred by diagnostic procedure options	Minimal	Low	Moderate	High
Risk conferred by therapeutic management options	Minimal	Low	Moderate	High
Bring results to BOX D. Final Results for Medical Decision-Making	Final Risk determined by highest level of any of the 3 components above			
	Minimal	Low	Moderate	High

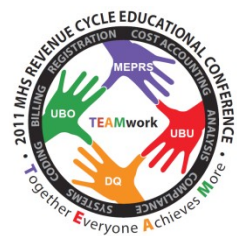


Leveling Decision for MDM - Box D

BOX D. Final Result for Complexity of Medical Decision-Making (MDM)

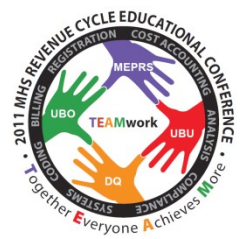
A	Number of diagnoses and/or management options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Amount and complexity of data reviewed or ordered	≤ 1 None/Minimal	2 Limited	3 Multiple	≥ 4 Extensive
C	Risk of complications and/or morbidity or mortality	Minimal	Low	Moderate	High

Type of medical decision-making	Final MDM requires that <u>2 of 3 of the above components are met or exceeded</u>			
	Straight Forward (S)	Low Complexity (L)	Moderate Complexity (M)	High Complexity (H)



Overall Leveling

EVALUATION AND MANAGEMENT (E & M) LEVEL OF SERVICE									
E & M Code	History	Exam	MDM	Average Time	E & M Code	History	Exam	MDM	Average Time
New Patient Office/Outpatient Requires 3 of 3 components met					Established Office/Outpatient Visit - Requires 2 of 3 components met. MDM must be 1 of the 2 required components met				
99201	PF	PF	S	10	99211	N/A	N/A	N/A	5
99202	EPF	EPF	S	20	99212	PF	PF	S	10
99203	D	D	L	30	99213	EPF	EPF	L	15
99204	C	C	M	45	99214	D	D	M	25
99205	C	C	H	60	99215	C	C	H	40



Reminder...

“If it’s not documented; it wasn’t done.”

NOT CODEABLE

Questions???



References

- Medicare Learning Network “Evaluation and Management Services Guide”, July 2009
- CPT® 2011 Professional Edition, American Medical Association
- DoD 6010.15-M, Military Treatment Facility Uniform Business Office (UBO) Manual, Nov 2006
- MHS Coding Guidelines, 2011
- Case excerpt from CPT® Reference of Clinical Examples, 2nd Edition